Patient's Name _____ Telephone No. _____ **TOXIC - SHOCK SY**

Address _____ *(Detach top portion*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL
ATLANTA, GEORGIA 30333

(scanned version only)

FORM APPROVED
OMB NO. 0920-0009

TOXIC - SHOCK SYNDROME CASE REPORT

Local Health Dept: Please send completed report, via your CD reporting staff, to: DHS/DCDC/IDB Surveillance & Statistics Section, P.O.Box 942732, MS 7306, Sacramento, CA 94234-7320

The First Three Letters of Patient's Last Name (1-3) ☐☐☐ | **CDC No.** (4-8) ☐☐☐☐☐ | **State No.** (9-10) ☐☐ | **State Case No.** (11-15) ☐☐☐☐☐

Age (16-17) ☐☐

Date of Birth Mo. (18-19) ☐☐ Day (20-21) ☐☐ Yr. (22-23) ☐☐

Sex (24): Male ☐ 1 Female ☐ 2

Outcome (25): Lived ☐ 1 Died ☐ 2

Race/Ethnicity (26): ☐ 1 White (not Hispanic) ☐ 2 Black (not Hispanic) ☐ 3 Hispanic ☐ 4 Asian/Pacific Islander ☐ 5 American Indian/Alaskan Native ☐ 9 Not Specified

Date of Onset of Symptoms Mo. (27-28) ☐☐ Day (29-30) ☐☐ Yr. (31-32) ☐☐

Date of Onset of Coincident Menstrual Period (If applicable) Mo. (33-34) ☐☐ Day (35-36) ☐☐ Yr. (37-38) ☐☐

Admitted to Hospital (39): Yes ☐ 1 No ☐ 2 Unk ☐ 9

Date of Hospital Admission Mo. (40-41) ☐☐ Day (42-43) ☐☐ Year (44-45) ☐☐

CASE CLASSIFICATION (46): Menstruation-associated ☐ 1 Wound-associated ☐ 2 Postpartum-associated ☐ 3 Other ☐ 4 (specify) _____

No. days postpartum ☐☐ (47-48)

CLINICAL FINDINGS Major Criteria

Fever (highest-if not recorded, leave blank) ☐☐☐.☐ F (49-52)

Hypotension (lowest) Systolic ☐☐☐ (53-55) Diastolic ☐☐ (56-57)

Syncope Yes ☐1 No ☐2 (58)

Orthostatic dizziness Yes ☐1 No ☐2 (59)

Rash (60) Yes ☐1 No ☐2 Unk. ☐9 (61) **If yes,** Generalized ☐1 Focal ☐2 **Describe:** _____

Desquamation (62) Yes ☐1 No ☐2 Unk. ☐9 **If yes,** describe: _____

SIGNS AND SYMPTOMS (First 4 Days of Illness)

	YES 1	NO 2	UNK 9
(63) Vomiting	☐	☐	☐
(64) Diarrhea	☐	☐	☐
(65) Abdominal pain	☐	☐	☐
(66) Myalgia	☐	☐	☐
(67) Sore throat	☐	☐	☐
(68) Conjunctival hyperemia	☐	☐	☐
(69) Oropharyngeal hyperemia	☐	☐	☐
(70) Injected tongue	☐	☐	☐
(71) Vaginal hyperemia	☐	☐	☐
(72) Vaginal discharge	☐	☐	☐
(73) Vaginal ulceration	☐	☐	☐
(74) Disorientation	☐	☐	☐
(75) Seizures	☐	☐	☐
(76) Cardiac Arrhythmia	☐	☐	☐

If Yes, describe _____

LABORATORY DATA (Most Abnormal Values in First 4 Days of Illness)

			Not Obtained
WBC Count (77-79)	☐☐.☐	000/mm³	(80) ☐
(81-82) Neutrophils	☐☐	%	(83) ☐
(84-85) Bands	☐☐	%	(86) ☐
(87-88) Metamyelocytes	☐☐	%	(89) ☐
(90-91) Myelocytes	☐☐	%	(92) ☐
(93-95) Platelets	☐☐☐	000/mm³	(96) ☐
(97-99) Highest platelet value after 7 days of illness	☐☐☐	000/mm³	
(100-102) SGOT	☐☐☐	IU/L	(103) ☐
(104-106) SGPT	☐☐☐	IU/L	(107) ☐
(108-110) Alkaline phosphatase	☐☐☐	IU/L	(111) ☐
(112-114) Bilirubin	☐☐.☐	mg/dl	(115) ☐
(116-119) Amylase	☐☐☐☐	Somogyi Units/dl	(120) ☐

Urinalysis

			Not Obtained
(121-122) WBC/HPF	☐☐	("Many" = 99)	(123) ☐
(124-125) RBC/HPF	☐☐	("Many" = 99)	(126) ☐
(127) Protein (0-4+)	☐		(128) ☐
(129-130) BUN	☐☐	mg/dl	(131) ☐
(132-134) Creatinine	☐☐.☐	mg/dl	(135) ☐
(136-138) Calcium	☐☐.☐	mg/dl	(139) ☐
(140-141) Phosphorus	☐.☐	mg/dl	(142) ☐
(143-144) Albumin	☐.☐	g/dl	(145) ☐
(146-149) Creatine phosphokinase (CPK)	☐☐☐☐	IU/L	(150) ☐

(151) CPK-myocardial band Yes ☐1 No ☐2 Unk ☐9 (152) ☐

(153) EKG Normal ☐1 Abnormal ☐2 Not obtained ☐3 Unk. ☐9 **If Abnormal,** describe _____

(154) Chest X-Ray Normal ☐1 Abnormal ☐2 Not obtained ☐3 Unk. ☐9 **If Abnormal,** describe _____

DROME CASE REPORT

e before sending to CDC.)

Physician's Name _____ Telephone No. _____

Address _____

CULTURES

BLOOD (155) Positive ☐ 1 Negative ☐ 2 Not Done ☐ 3 Unk ☐ 9 **If Positive,** what organism(s): 1 _____ (156-157) 2 _____ (158-159)

URINE (160) Positive ☐ 1 Negative ☐ 2 Not Done ☐ 3 Unk ☐ 9 **If Positive,** what organism(s): 1 _____ (161-162) 2 _____ (163-164)

Colony Count 1. ☐☐☐ 000/ml (165-167) 2. ☐☐☐ 000/m (168-17

THROAT (171) Normal Flora ☐ 1 Abnormal ☐ 2 Not Done ☐ 3 Unk ☐ 9 **If Abnormal,** what organism(s): 1. _____ (172-173) 2. _____ (174-175)

NARES (176) Done ☐ 1 Not Done ☐ 3 Unk ☐ 9 **If Done,** what organism(s): 1. _____ (177-178) 2. _____ (179-180)

VAGINA (181) Done ☐ 1 Not Done ☐ 3 Unk ☐ 9 **If Done,** what organism(s): 1. _____ (182-183) 2. _____ (184-185)

Was *Staphylococcus aureus* present in the vagina? (186) **Yes** ☐ 1 **No** ☐ 2 **Unk** ☐ 9

If *S. aureus* present in vagina, is it resistant to penicillin and ampicillin only? (187) **Yes** ☐ 1 **No** ☐ 2 **Unk** ☐ 9

Other Site(s) _____ (188-189) **Organism(s)** 1. _____ (190-191) 2. _____ (192-193)

Was patient taking antibiotics when culture(s) performed? (194) **Yes** ☐ 1 **No** ☐ 2 **Unk.** ☐ 9 **If yes, which sites?** _____ (195-196)

TAMPON/NAPKIN/MINIPAD USE – IF APPLICABLE (During Period When Patient Became Ill)

PRODUCTS USED (197-198)

Tampon only ☐ 1 Minipad only ☐ 3 Tampon and Minipad ☐ 5 Tampon, Napkin, and Minipad ☐ 7 Other _____ (199-200) ☐ 1

Napkin only ☐ 2 Tampon and Napkin ☐ 4 Napkin and Minipad ☐ 6 Sea Sponge ☐ 8 Unknown ☐

(If Only One Brand Was Used Before Onset of Symptoms, List Only That Brand)

BRAND # 1 (Most frequently used, judged by time)

NAME (201-202)

		STYLE (ABSORBENCY) (203)	
Assure	☐ 1	Super-plus	☐ 1
Kotex		Super	☐ 2
Plastic Inserter	☐ 2	Regular	☐ 3
Stick Inserter	☐ 3	Junior	☐ 4
Inserter Unk	☐ 4	Unknown	☐ 9
o.b.	☐ 5		
Playtex			
Deodorized	☐ 6		
Non-deodorized	☐ 7		
Deodorant unk	☐ 8		
Pursettes	☐ 10		
Rely	☐ 11		
Tampax	☐ 12		
Other (specify) _____	☐ 13		
Unknown	☐ 9		

BRAND # 2

NAME (204-205)

		STYLE (ABSORBENCY) (206)	
Assure	☐ 1	Super-plus	☐ 1
Kotex		Super	☐ 2
Plastic inserter	☐ 2	Regular	☐ 3
Stick inserter	☐ 3	Junior	☐ 4
Inserter unk	☐ 4	Unknown	☐ 9
o.b.	☐ 5		
Playtex			
Deodorized	☐ 6		
Non-deodorized	☐ 7		
Deodorant unk	☐ 8		
Pursettes	☐ 10		
Rely	☐ 11		
Tampax	☐ 12		
Other (specify) _____	☐ 13		
Unknown	☐ 9		

Was Brand No. 1 the only tampon brand used during period when patient became ill? (207) **Yes** ☐ 1 **No** ☐ 2 **Unk.** ☐ 9

NAPKIN BRAND: _____ (208-209)

MINIPAD BRAND: _____ (210-211)

How was information in this section verified? (212)

Patient's Memory ☐ 1

Patient viewing product box ☐ 2

Interviewer viewing product box ☐ 3

Other (describe) ☐ 4 _____

RECURRENCE INFORMATION FOR MENSTRUATION - ASSOCIATED CASES

Has patient had similar illness in past during menstrual period? (213) **Yes** ☐ 1 **No** ☐ 2 **Unk.** ☐ 9 **If yes,** how many episodes? (214) One ☐ 1 Two ☐ 2 Three ☐ 3 More than Three ☐ 4

OTHER INFORMATION

Please describe any other pertinent or unusual features of this case _____

How was case reported to Health Department? (215) By patient or relative ☐ 1 By physician ☐ 2 By hospital ☐ 3 Other ☐ 4

FOR CDC USE ONLY ☐ 1 ☐ 2 (228) ☐ 3 ☐ 4

Person Completing Form	**Date Reported to Health Department** (216-221)	**Date Form Completed** (222-227)